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10 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
**DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the First Amended Accusation  
Against:

13 RONALD JAMES CRUZ,  
14 a.k.a. RONALD CRUZ  
1205 Dominion Drive  
15 Redding, CA 96002

16 Registered Nurse License No. 562986

17 Respondent.

Case No. 2008-60

**FIRST AMENDED  
ACCUSATION**

18 Complainant alleges:

19 **PARTIES**

20 1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this First Amended  
21 Accusation solely in her official capacity as the Executive Officer of the Board of Registered  
22 Nursing ("Board"), Department of Consumer Affairs. This First Amended Accusation replaces  
23 nunc pro tunc the Accusation heretofore filed.

24 2. On or about January 26, 2000, the Board issued Registered Nurse License  
25 Number 562986 to Ronald James Cruz, also known as Ronald Cruz ("Respondent").  
26 Respondent's registered nurse license was in full force and effect at all times relevant to the  
27 charges brought herein and will expire on December 31, 2009, unless renewed.

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1                   7.       Code section 2770.11 states:

2                   (a) Each registered nurse who requests participation in a diversion  
3                   program shall agree to cooperate with the rehabilitation program designed by a  
4                   committee. Any failure to comply with the provisions of a rehabilitation program  
5                   may result in termination of the registered nurse's participation in a program. The  
6                   name and license number of a registered nurse who is terminated for any reason,  
7                   other than successful completion, shall be reported to the board's enforcement  
8                   program.

9                   (b) If a committee determines that a registered nurse, who is denied  
10                  admission into the program or terminated from the program, presents a threat to  
11                  the public or his or her own health and safety, the committee shall report the name  
12                  and license number, along with a copy of all diversion records for that registered  
13                  nurse, to the board's enforcement program. The board may use any of the records  
14                  it receives under this subdivision in any disciplinary proceeding.

15                  8.       Code section 4022 states:

16                  "Dangerous drug" or "dangerous device" means any drug or device unsafe  
17                  for self-use in humans or animals, and includes the following:

18                  (a) Any drug that bears the legend: "Caution: federal law prohibits  
19                  dispensing without prescription," "Rx only," or words of similar import.

20                  (b) Any device that bears the statement: "Caution: federal law restricts this  
21                  device to sale by or on the order of a -----," "Rx only," or words of similar  
22                  import, the blank to be filled in with the designation of the practitioner licensed to  
23                  use or order use of the device.

24                  (c) Any other drug or device that by federal or state law can be lawfully  
25                  dispensed only on prescription or furnished pursuant to Section 4006.

26                  9.       Code section 4060 states, in pertinent part:

27                  No person shall possess any controlled substance, except that furnished to  
28                  a person upon the prescription of a physician, dentist, podiatrist, optometrist,  
29                  veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished  
30                  pursuant to a drug order issued by a certified nurse-midwife pursuant to Section  
31                  2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant  
32                  pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or  
33                  a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause  
34                  (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.  
35                  This section shall not apply to the possession of any controlled substance by a  
36                  manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist,  
37                  optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse  
38                  practitioner, or physician assistant, when in stock in containers correctly  
39                  labeled with the name and address of the supplier or producer . . .

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10. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that “[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . .”

#### **DANGEROUS DRUG AT ISSUE**

11. “**Dilaudid**”, a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

12. “**Tramadol**”, a brand of Ultram, is a dangerous drug within the meaning of Code section 4022 in that it is available by prescription only.

#### **COST RECOVERY**

13. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

#### **RESPONDENT’S TERMINATION FROM BOARD’S**

##### **DIVERSION PROGRAM AS A PUBLIC RISK**

14. On or about February 14, 2006, Respondent was enrolled in the Board’s Diversion Program. On or about November 1, 2006, the Diversion Evaluation Committee (“DEC”) terminated Respondent from the Diversion Program for noncompliance/public risk due to the following: Respondent was a traveling nurse registered in other states who discontinued phoning Compass Vision, Inc. (“CVI”)<sup>1</sup>; On October 9, 2006, Respondent discontinued attending Nurse Support Group (“NSG”) and contacting MAXIMUS<sup>2</sup>; On October 4, 2006, Respondent’s worksite monitor reported that Respondent’s eyes looked funny, he was distracted, and made errors at work; On October 3, 2006, NSG felt that Respondent was “loaded”; Respondent refused to participate in NSG; Respondent missed individual counseling

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1. CVI is a provider of testing solutions for healthcare monitoring programs nationwide.

2. MAXIMUS is a private entity, contracted by the Board, which monitors nurses who have entered into the Diversion Program.

1 sessions at the treatment center; and Respondent failed to respond to numerous verbal and  
2 written contact attempts by MAXIMUS.

3 **FIRST CAUSE FOR DISCIPLINE**

4 **(Self-Administration of a Dangerous Drug)**

5 15. Respondent agreed, as a condition of his participation in the Board's  
6 Diversion Program, that he would comply with all elements of his rehabilitation plan, including  
7 submitting to random body fluid screenings.

8 16. On or about March 31, 2006, Respondent submitted to a random urine  
9 drug screening and tested positive for the dangerous drug Tramadol.

10 17. Respondent is subject to disciplinary action pursuant to Code section  
11 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section  
12 2762, subdivision (a), based upon the following: On or about March 31, 2006, Respondent self-  
13 administered the dangerous drug Tramadol without lawful authority therefor.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Disciplinary Action by the Idaho State Board of Nursing)**

16 18. Respondent is subject to disciplinary action pursuant to Code section  
17 2761, subdivision (a)(4), on the grounds of unprofessional conduct. On or about November 2,  
18 2006, pursuant to the Findings of Fact, Conclusions of Law and Final Order of the Idaho State  
19 Board of Nursing ("Idaho Board") in the disciplinary action titled *In the Matter of the License of:*  
20 *Ronald Cruz, License No. N-27005*, Case No. BON 06-014, the Board revoked Respondent's  
21 license. The Idaho Board's discipline was based upon the following conduct of Respondent,  
22 including, but not limited to: Using controlled substances, failing to account for narcotics/  
23 controlled substances as evidenced on multiple Pyxis and medication administration records, and  
24 diverting controlled substances. A true and correct copy of the Findings of Fact, Conclusions of  
25 Law and Final Order is attached as exhibit "A" and incorporated herein by reference.

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28 **THIRD CAUSE FOR DISCIPLINE**

1                                   **(Diversion and Possession of a Controlled Substance)**

2                   19.     Respondent is subject to disciplinary action pursuant to Code section  
3 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section  
4 2762, subdivision (a), as follows: Respondent was employed as a registered nurse by NPH  
5 Medical Services, a staffing agency. On December 17, 2005, and December 18, 2005,  
6 Respondent was assigned to work the night shift in the Adult/Pediatric Services and Education  
7 Department ("APSED") at St. Elizabeth Community Hospital in Red Bluff, California, when he  
8 did the following:

9                           **Diversion of a Controlled Substance:**

10                   a.     Respondent obtained the controlled substance Dilaudid by fraud, deceit,  
11 misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173,  
12 subdivision (a), as follows: On December 17, 2005, and December 18, 2005, Respondent, by his  
13 own admission, removed varying quantities of Dilaudid from the Med Select Diebold<sup>3</sup> ("MSD")  
14 under the names of several different patients when there were no physicians' orders authorizing  
15 the medication for the patients, or the quantities of the medication removed from the MSD were  
16 in excess of the doses ordered by the patients' physicians.

17                           **Possession of a Controlled Substance:**

18                   b.     On and between December 17, 2005, and December 18, 2005, Respondent  
19 possessed unknown quantities of the controlled substance Dilaudid without a valid prescription  
20 from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation  
21 of Code section 4060.

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26                                   **PRAYER**

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28                   3. The Med Select Diebold is an automated narcotic medication dispensing system.

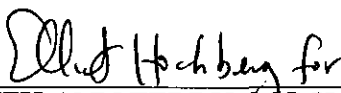
1 WHEREFORE, Complainant requests that a hearing be held on the matters herein  
2 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

3 1. Revoking or suspending Registered Nurse License Number 562986, issued  
4 to Ronald James Cruz, also known as Ronald Cruz;

5 2. Ordering Ronald James Cruz, also known as Ronald Cruz, to pay the  
6 Board of Registered Nursing the reasonable costs of the investigation and enforcement of this  
7 case, pursuant to Business and Professions Code section 125.3; and

8 3. Taking such other and further action as deemed necessary and proper.  
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10  
11 DATED: 1/25/09  
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13   
14 RUTH ANN TERRY, M.P.H., R.N.  
15 Executive Officer  
16 Board of Registered Nursing  
17 Department of Consumer Affairs  
18 State of California  
19 Complainant  
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**EXHIBIT A**  
**FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER**



## BEFORE THE IDAHO STATE BOARD OF NURSING

In the Matter of the License of:	)	
	)	Case No. BON 06-014
RONALD CRUZ,	)	
License No. N-27005,	)	<b>FINDINGS OF FACT,</b>
	)	<b>CONCLUSIONS OF LAW AND</b>
Respondent.	)	<b>FINAL ORDER</b>
	)	

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Nursing\Cruz\P6289lka

Having reviewed the Complaint and other documents filed in this matter, the Idaho State Board of Nursing (hereinafter the "Board") enters the following Findings of Fact, Conclusions of Law, and Order:

### FINDINGS OF FACT

1. Ronald Cruz ("Respondent") is licensed by the Idaho State Board of Nursing under License No. N-27005 to engage in the practice of nursing in the State of Idaho.
2. At all times relevant herein, Respondent worked as a traveling nurse through Cross Country TravCorps.
3. On January 31, 2006, Respondent reported for employment to Saint Alphonsus Regional Medical Center (SARMC) and took a pre-employment drug screen.
4. On February 3, 2006, the Pyxis records showed that Respondent removed a 100 mg. vial of Fentanyl for patient RO at 1958 and at 2004. Both doses were subsequently noted in Pyxis as having been wasted at 2040. There was no order for Fentanyl for the patient, and Respondent was unable to adequately explain why it took him approximately 36 minutes to waste the two vials of Fentanyl.
5. On February 6, 2006, the Pyxis machine recorded that Respondent removed Soma for patient RO at 2026. Respondent was not assigned to patient RO on that shift. On the same shift, Respondent also removed Soma doses for patient RO at 0037 and 0334 (on February 7, 2006). None of the Soma doses were recorded on the MAR and there

was no note anywhere in the medical record to indicate that patient RO needed Soma or that the doses removed from the Pyxis machine were administered. The nurse assigned to patient RO reported that RO was his only patient that night, that RO had a very good night, was given the minimum dose of oral Hydrocodone at 1945 and required no other pain or muscle relaxing medication throughout the night, and that Respondent did not assist in the care of patient RO that shift. At no time during the shift did Respondent apprise the nurse assigned to patient RO that he had provided a PRN medication or that he provided three doses throughout the night.

6. When Respondent removed one Soma from the Pyxis machine on February 6, 2006, at 2026 for patient RO, the count when the drawer was opened was 20, and when the transaction was completed it was recorded and agreed to by Respondent as 19. The drawer then malfunctioned, and Respondent unsuccessfully attempted a number of times during the night to "recover" the drawer. The other Soma Respondent obtained for patient RO during that shift were subsequently taken from another Pyxis machine. At 0506 on February 7, 2006, a pharmacy staff member recovered the drawer and opened it for inventory count. The count at that time was 16, indicating three Soma were unaccounted for. On February 8, 2006, the Pyxis company representative opened the back of the Pyxis machine and found no loose medications.

7. On February 7, 2006, the SARMC Director of Nursing was informed by the Occupational Health nurse that Respondent's pre-employment drug sample was positive for Methadone. On that date, SARMC temporarily suspended Respondent from duty pending investigation.

8. On February 8, 2006, Respondent was terminated from SARMC.

9. On August 25, 2006, the Board filed a formal Complaint against Respondent. Said Complaint is expressly incorporated herein and made a part hereof.

10. Copies of the Complaint, along with the Notification of Procedural Rights, were sent to Respondent on August 25, 2006, by United States Mail, postage prepaid,

both by certified mail, return receipt requested, and by regular mail. The mailings were addressed to Respondent at his most recent home address on file with the Board, as follows:

Ronald Cruz  
1205 Dominion Drive  
Redding, CA 96002

11. The Board received back from the post office the certified mail return receipt indicating that the copy of the Complaint sent by certified mail was received at Respondent's address on August 29, 2006. The Board did not receive back from the post office the envelope containing a copy of the Complaint which was sent to Respondent by regular mail.

12. The Notification of Procedural Rights informed Respondent that, under statutes and rules applicable to such proceedings before the Board, Respondent needed to file a formal Answer to the Complaint within twenty-one (21) days of service of the Complaint and that failure to timely file an Answer to the Complaint or otherwise defend against the action would constitute a default and would be sufficient grounds for proceeding administratively against Respondent's license without the necessity of conducting a hearing.

13. On September 20, 2006, a Notice of Intent to Take Default was sent to Respondent by United States Mail, postage prepaid, both by certified mail, return receipt requested, and by regular mail, to Respondent at his address of record with the Board.

14. The Board received back from the post office the certified mail return receipt indicating that the copy of the Notice of Intent to Take Default sent by certified mail was received at Respondent's address on September 23, 2006. The Board did not receive back from the post office the envelope containing a copy of the Complaint which was sent to Respondent by regular mail.

15. Respondent failed to appear or otherwise defend at the hearing scheduled

during the Board meeting that took place on November 2-3, 2006, as advised in the Notice of Intent.

### CONCLUSIONS OF LAW

1. As a licensed nurse in the State of Idaho, Respondent is subject to the jurisdiction of the Board and to the provisions of title 54, chapter 14, Idaho Code.
2. The Complaint was sent to Respondent at the address on file with the Board. Respondent was duly and lawfully given notice of proceedings against his license pursuant to the provisions of IDAPA 04.11.01.055.
3. Respondent's failure to plead or otherwise defend in this action authorizes the Board, pursuant to Idaho Code § 67-5242(4) and IDAPA 04.11.01.700, to enter an Order of Default which is as lawful as if all the allegations in the Complaint were proved or admitted at a hearing.
4. Respondent's acts as detailed in the incorporated Complaint constitute violations of Idaho Code § 54-1413(1)(g) and Board Rules (IDAPA 23.01.01) 100.08, 100.09, 101.04.e, 101.04.i, 101.04.j, 101.05.d, 101.05.e, and 101.05.f, thereby authorizing the Board to impose sanctions against Respondent pursuant to Idaho Code §§ 54-1413(3)(a) and 67-5242(4).

### ORDER

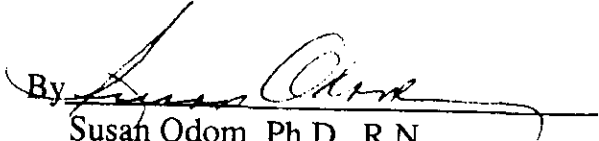
Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause being shown, it is hereby ordered that:

1. Pursuant to Idaho Code § 67-5242(4) and IDAPA 04.11.01.700, Respondent is in default.
2. License No. N-27005 issued to Ronald Cruz is:  
    ☒ Revoked  
    \_\_\_\_\_ Suspended \_\_\_\_\_ days/year(s) \_\_\_\_\_ indefinitely
3. Any application for reinstatement of licensure by Respondent shall be subject to the provisions of Idaho Code § 54-1411(3) and IDAPA 23.01.01.120.

This order is effective immediately.

DATED this 21<sup>st</sup> day of November, 2006.

IDAHO STATE BOARD OF NURSING

By   
Susan Odom, Ph.D., R.N.  
Chair

### NOTICE OF DUE PROCESS RIGHTS

This is a final order of the Board. Any party may file a motion for reconsideration of this final order within fourteen (14) days of the service date of this order. The Board will dispose of the petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. See Idaho Code § 67-5246(4).

Pursuant to Idaho Code §§ 67-5270 and 67-5272, any party aggrieved by this final order or orders previously issued in this case may appeal this final order and all previously issued orders in this case to district court by filing a petition in the district court of the county in which:

- a. A hearing was held,
- b. The final agency action was taken,
- c. The party seeking review of the order resides, or
- d. The real property or personal property that was the subject of the agency action is located.

An appeal must be filed within twenty-eight (28) days (a) of the service date of this final order, (b) of an order denying petition for reconsideration, or (c) the failure within twenty-one (21) days to grant or deny a petition for reconsideration, whichever is later. See Idaho Code § 67-5273. The filing of an appeal to district court does not itself stay the effectiveness or enforcement of the order under appeal.